No. 2
—5-42
5-17-39
X32873

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

STATE BOARD OF HEALTH OF MISSOURI

STANDARD CERTIFICATE OF DEATH

State File No. 31467

Registration District No. 71 — Primary Registration District No. 3012 — Registrar's No. 332

FILED OCT 7 1943

1. PLACE OF DEATH:
(a) County: Clay
(b) City or town: Excelsior Springs, Mo. (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: Veterans Administration Facility (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution 4 mos. 9 days (Specify whether years, months or days)
In this community 4 mos. 9 days

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City (If outside city or town limits, write "RURAL")
(d) Street No.: 609 East 10th St. (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country: /

3. (a) PRINT FULL NAME: Grant Watson
3. (b) If veteran, name war: Philippine Insurrection
3. (c) Social Security No.: 496-09-4061
4. Sex: Male
5. Color or race: Colored
6. (a) Single, widowed, married, divorced: Married
6. (b) Name of husband or wife: Laney Watson
6. (c) Age of husband or wife if alive: 55 years
7. Birth date of deceased: April 2, 1883 (Month) (Day) (Year)

8. AGE: Years 60 | Months 5 | Days 14 | If less than one day ___ hr. ___ min.

9. Birthplace: Tampa, Florida (City, town, or county) / (State or foreign country)
10. Usual occupation: Janitor - unemployed
11. Industry or business: QMC Depot
FATHER 12. Name: Not known
FATHER 13. Birthplace: - (City, town, or county) 9 (State or foreign country)
MOTHER 14. Maiden name: Mary ?
MOTHER 15. Birthplace: - (City, town, or county) Florida (State or foreign country)
16. (a) Informant: Hospital Records, Veterans Administration
(b) Address: Excelsior Springs, Mo.
17. (a) Removal (Burial, cremation, or removal) (b) Date thereof: 9-19-43 (Month) (Day) (Year)
(c) Place: burial or cremation: Kansas City, Mo.
18. (a) Signature of funeral director: Herbert Hope
(b) Address: Excelsior Springs Mo.
19. (a) 9-19-43 (Date received local registrar) (b) Mrs Sadie Redman (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month September day 16 year 1943 hour 2:05 minute P. M.
21. I hereby certify that I attended the deceased from May 7, 1943 to September 16, 1943 that I last saw him alive on September 16, 1943 and that death occurred on the date and hour stated above.

Immediate cause of death	Duration
Tuberculosis, pulmonary, chronic active, far advanced	unknown
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy: No autopsy	

PHYSICIAN — Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify): -
(b) Date of occurrence: -
(c) Where did injury occur? (City or town) (County) (State): -
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place): -
While at work? (e) Means of injury: -

23. Signature: Forrest G. Bell (M. D. or other) MD
Address: FORREST G. BELL, Veterans Administration, Excelsior Springs, Mo. Date signed 9-17-43

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 8,
District File Number
Date Filed 10-7-43

JAN 16 1946

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by ....., Registered Apprentice No. ....., working under my personal supervision.

Signed .....

Licensed Embalmer No. 3296.

P. O. Address Ex Springs Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.